

# Athlete Yearly Update Form - optional

**Complete ONLY if athlete has current medical and release form on file.**

County \_\_\_\_\_ School/Agency \_\_\_\_\_

Athlete First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Sex (M or F) \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age \_\_\_\_\_  
month      day      year

Soc. Sec. # \_\_\_\_\_ School/Agency \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

Street Address (if different than athlete) \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
(please provide different number than athlete phone)

Parent/Guardian email address \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Emerg. Phone (\_\_\_\_) \_\_\_\_\_

List sports that you want to participate in this year: \_\_\_\_\_

T-shirt size: Children -  S  M  L      Adult -  S  M  L  XL  XXL

Shorts size: Children -  S  M  L      Adult -  S  M  L  XL  XXL

**MEDICAL INFORMATION**

Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Describe any major medical problems that have occurred with the past 12 months: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List allergies to medications, insect stings or foods: \_\_\_\_\_

\_\_\_\_\_

**Current Prescribed Medications:**

Medication Name	Dosage	Frequency	Date Prescribed	Prescribed for Following Condition(s)	Physician Name/ Telephone

**If necessary, list additional medications on separate sheet of paper.**

**APPLICATION FOR PARTICIPATION (Medical Form)**  
(must be completed and signed by licensed examiner every 3 years)



COUNTY: \_\_\_\_\_ School/Agency: \_\_\_\_\_

SSN: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ T-shirt Size: \_\_\_\_\_ Children: \_\_\_\_\_ OR Adult: \_\_\_\_\_

**LAST NAME** \_\_\_\_\_ **FIRST** \_\_\_\_\_ **SEX** \_\_\_\_\_ **DATE OF BIRTH** \_\_\_\_\_  
M or F month/day/year

Street Number/Address \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

Address (if different) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Emergency Contact (other than parent/guardian) \_\_\_\_\_ Emerg. Phone (\_\_\_\_) \_\_\_\_\_

Health Insurance Company \_\_\_\_\_ Ins. Policy # \_\_\_\_\_

Signature of parent/guardian/adult athlete completing form \_\_\_\_\_

**FOR ATHLETES WITH DOWN SYNDROME** -- Persons with Down syndrome should have a lateral x-ray of the cervical spine in hyperflexion and hyperextension. The interpretation of the radiographs should include measurements of the atlanto-dens interval.

Yes  No Has an x-ray evaluation for atlantoaxial instability been done?

Yes  No If yes, was it positive for atlantoaxial instability? (positive indicates that the atlanto-dens interval is 5mm or more)

**IS THERE PRESENT OR A HISTORY OF (to be completed by parent/caregiver):**

- |                                    |                              |                                  |                              |   |                              |
|------------------------------------|------------------------------|----------------------------------|------------------------------|---|------------------------------|
| Heart problems/high blood pressure | <input type="checkbox"/> Yes | Tobacco use                      | <input type="checkbox"/> Yes | Emotional/psychiatric/behavioral problems   | <input type="checkbox"/> Yes |
| Chest pain                         | <input type="checkbox"/> Yes | Major surgery or serious illness | <input type="checkbox"/> Yes | Asthma/breathing problems with exertion     | <input type="checkbox"/> Yes |
| Seizures/epilepsy/fainting spells  | <input type="checkbox"/> Yes | Heat stroke/exhaustion           | <input type="checkbox"/> Yes | Contact lenses/glasses/dentures/false teeth | <input type="checkbox"/> Yes |
| Diabetes                           | <input type="checkbox"/> Yes | Easy bleeding                    | <input type="checkbox"/> Yes | Head injury/history of concussion           | <input type="checkbox"/> Yes |
| Hearing aid/hearing problems       | <input type="checkbox"/> Yes | Bone/joint problems              | <input type="checkbox"/> Yes | Immunizations (shots) are up-to-date        | <input type="checkbox"/> Yes |
| Blindness/vision problem           | <input type="checkbox"/> Yes | Sickle cell disease or trait     | <input type="checkbox"/> Yes | Special Diet Needs (list below)             | <input type="checkbox"/> Yes |
| Absence of one kidney or testicle  | <input type="checkbox"/> Yes | Uses a wheelchair                | <input type="checkbox"/> Yes | Year of last tetanus shot _____             |                              |

Other problems that would interfere with participation \_\_\_\_\_

Allergy to the following (list specific):

Food \_\_\_\_\_ Insect sting/bites \_\_\_\_\_

Medication \_\_\_\_\_

**MEDICATIONS**

Medication Name	Dosage	Date Presc.	Times per day	Medication Name	Dosage	Date Presc.	Times per day

**PHYSICAL EXAMINATION**

- |                      |         |                                 |                                   |              |                                 |                                   |                         |                                 |                                   |
|----------------------|---------|---------------------------------|-----------------------------------|--------------|---------------------------------|-----------------------------------|-------------------------|---------------------------------|-----------------------------------|
| Blood Pressure _____ | Vision  | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> | Oral Cavity  | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> | Cardiovascular system   | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> |
| Pulse _____          | Hearing | <input type="checkbox"/>        | <input type="checkbox"/>          | Extremities  | <input type="checkbox"/>        | <input type="checkbox"/>          | Respiratory system      | <input type="checkbox"/>        | <input type="checkbox"/>          |
| Weight _____         | Neck    | <input type="checkbox"/>        | <input type="checkbox"/>          | Coordination | <input type="checkbox"/>        | <input type="checkbox"/>          | Gastrointestinal system | <input type="checkbox"/>        | <input type="checkbox"/>          |
| Height _____         | Skin    | <input type="checkbox"/>        | <input type="checkbox"/>          | Reflexes     | <input type="checkbox"/>        | <input type="checkbox"/>          | Genitourinary system    | <input type="checkbox"/>        | <input type="checkbox"/>          |
|                      |         |                                 |                                   |              |                                 |                                   | Cranial nerves          | <input type="checkbox"/>        | <input type="checkbox"/>          |

Other: \_\_\_\_\_

Primary MR Etiology/Category \_\_\_\_\_

I have reviewed the above health information and examined the athlete named in the application and certify that there is no medical evidence available to me which would preclude the athlete's participation in Special Olympics.

Restrictions \_\_\_\_\_  
Examiner's Name: \_\_\_\_\_ Certification:  MD  DO  DC  PA  ARNP

**EXAMINER'S SIGNATURE** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**OPTIONAL INFORMATION**

Ethnic background:  Asian  African American  Caucasian  Hispanic  Native American  Other \_\_\_\_\_

# OFFICIAL SPECIAL OLYMPICS RELEASE FORM

(SPECIAL OLYMPICS FLORIDA SPORTS INFORMATION GUIDE 2007 – 2008)



**Special Olympics  
Florida**

COUNTY: \_\_\_\_\_

SCHOOL/AGENCY: \_\_\_\_\_

ATHLETE NAME Last: \_\_\_\_\_ First: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
month day year

I represent and warrant that, to the best of my knowledge and belief, I (or my minor child) am (is) physically and mentally able to participate in Special Olympics activities. I also represent that a licensed physician has reviewed the health information contained in my (or my minor child's) application and has certified, based on an independent medical examination, that there is no medical evidence which would preclude me (or my minor child) from participating in Special Olympics. I understand that if I (or my minor child) have (has) Down Syndrome, I (or my minor child) cannot participate in sports or events which, by their nature, result in hyper-extension, radical flexion or direct pressure on my (or my minor child's) neck or upper spine unless I and two physicians have completed the official "Special Release for Athletes with Atlanto-Axial Instability," available from the Special Olympics Program in my area, or I (or my minor child) have (has) had a full radiological examination which establishes the absence of Atlanto-Axial Instability. I am aware that if I choose not to complete the "Special Release for Athletes with Atlanto-Axial Instability" form which establishes the absence of Atlanto-Axial Instability, I (or my minor child) must have the radiological examination before I (or my minor child) can participate in equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, squat lift and football (soccer).

Special Olympics has my permission, (both during and anytime after), to use my (or my minor child's) likeness, name, voice or words in either television, radio, film, newspapers, magazines, and other media, and in any form, for the purpose of advertising or communicating the purposes and activities of Special Olympics and/or applying for funds to support these purposes and activities.

## **TO BE COMPLETED BY ADULT ATHLETE**

**OR**

## **TO BE COMPLETED BY PARENT/GUARDIAN OF MINOR ATHLETE**

If, during my participation in Special Olympics activities, I should need emergency treatment, and I am not able to give my consent or make my own arrangements for that treatment because of my injuries, I authorize Special Olympics to take whatever measures are necessary to protect my health and well-being, including, if necessary, hospitalization.

I understand that it is my responsibility to acquire, review and complete the Athlete Code of Conduct form for the safety and health of both myself and my fellow athletes.

I am at least 18 years old and have submitted the attached application for participation in Special Olympics. I have read this paper and fully understand the provisions of the release that I am signing. I understand that by signing this paper, I am saying that I agree to the provisions of this release.

\_\_\_\_\_  
Signature of Adult Athlete

\_\_\_\_\_  
Date

I hereby certify that I have reviewed this release with the athlete whose signature appears above. I am satisfied, based on that review, that the athlete understands this release and has agreed to its terms.

Name (print): \_\_\_\_\_

Relationship to athlete: \_\_\_\_\_

If a medical emergency should arise during the minor athlete's participation in any Special Olympics activities, at a time when I am not personally present so as to be consulted regarding the athlete's care, I hereby authorize Special Olympics, on my behalf, to take whatever measures are necessary to ensure that the athlete is provided with any emergency medical treatment, including hospitalization, which Special Olympics deems advisable in order to protect the minor athlete's health and well-being.

I understand that it is my responsibility to acquire, review and complete the Athlete Code of Conduct form, with and for my athlete, for the safety and health of both my child/guard and their fellow athletes.

I am the parent/guardian of the minor athlete named in this application. I have read and fully understand the provisions of the above release, and have explained these provisions to the athlete. Through my signature on this release form, I am agreeing to the above provisions on my own behalf and on the behalf of the athlete named above. I hereby give permission for the athlete named above to participate in Special Olympics games, recreation programs and physical activity programs.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date



Special Olympics



# HEALTHY ATHLETE CONSENT FORM

Athlete's Name (please print): \_\_\_\_\_  
First Last

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ County: \_\_\_\_\_  
Month Day Year

Special Olympics offers certain non-invasive health care services to athletes at local, state, national, and World Games venues through the Healthy Athletes Program. These services may include individual screening assessments of health status and healthcare needs, provision of health education, routine preventive services (e.g., protective mouth guards), educational services, and, in the case of vision and hearing deficits, provision of needed eyewear (glasses, swim goggles, protective eyewear) and hearing aids. Athletes are informed as to their health status and advised of the need for follow-up care. In addition, information collected at the time services are provided has been invaluable for developing policies, securing resources, and implementing programs to better meet the health needs of athletes.

### Adult Athlete:

I understand that by signing below, I consent to participate in the Special Olympics Healthy Athletes program that provides individual screening assessments of health status and healthcare needs in the areas of: vision, oral health, hearing, physical therapy, and a variety of health promotion areas (height, weight, sun protection, etc.). I understand there is no obligation for me to participate in the Healthy Athletes Program should I decide not to participate. Provision of these health services is not intended as a substitute for regular care. I also understand that I should seek my own independent medical advice and assistance, irrespective of the provisions of these services and that Special Olympics is not through the provision of these provisions responsible for my health. I understand that information that is gathered as part of the screening process may be used in group form (anonymously) to assess and communicate the overall health needs of athletes and to develop programs to address those needs.

\_\_\_\_\_  
Signature of Adult Athlete

\_\_\_\_\_  
Date

OR

### Parent/Guardian of Minor Athlete:

Parent/Guardian or Minor Athlete  
I understand that by signing below, I consent to the above athlete's participation in the Special Olympics Healthy Athletes program that provides individual screening assessments of health status and healthcare needs in the areas of: vision, oral health, hearing, physical therapy, and a variety of health promotion areas (height, weight, sun protection, etc.). I understand there is no obligation for the athlete named above to participate in the Healthy Athletes Program should the athlete decide not to participate or should I decide the athlete shall not participate. Provision of these health services is not intended as a substitute for regular care. I also understand that I should seek my own independent medical advice and assistance irrespective of the provisions of these services for the athlete named above and that Special Olympics is not through the provision of these provisions responsible for the health of the athlete named above. I understand that information that is gathered as part of the screening process may be used in group form (anonymously) to assess and communicate the overall health needs of athletes and to develop programs to address those needs.

\_\_\_\_\_  
Printed Name of Parent/Guardian

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

**NOTE: This authorization shall remain effective unless the consenting party requests termination or the scope of the Healthy Athletes program changes materially.**

# ATLANTO-AXIAL INSTABILITY STATUS FORM FOR ATHLETES WITH DOWN SYNDROME



COUNTY: \_\_\_\_\_ SCHOOL/AGENCY: \_\_\_\_\_

ATHLETE NAME Last: \_\_\_\_\_ First: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
month day year

<p>A cervical vertebrae x-ray study shows that the above athlete (check one)</p> <p>_____ does have _____ does not have</p> <p>evidence of Atlanto-axial Instability.</p>
---

Physician Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Physician Name (please print): \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Physician Title/Certification: \_\_\_\_\_ Date: \_\_\_\_\_

**If the above athlete does have Atlanto-Axial Instability then they will be restricted from the sports/events listed below unless they submit a “Special Release for Athletes with Atlanto-axial Instability Form”. This form details any restrictions an athlete may have, the name, address and signature of two examining physicians and the signature of the adult athlete and witness or the parent/guardian of a minor athlete.**

**Restricted sports training and competition activities include:** butterfly stroke, diving starts in swimming, diving, pentathlon, high jump, equestrian sports, artistic gymnastics, football (soccer), squat lift, alpine skiing and any warm-up exercise placing undue stress on the head and neck.

# ATLANTO-AXIAL INSTABILITY RELEASE FORM

COUNTY: \_\_\_\_\_ SCHOOL/AGENCY: \_\_\_\_\_

ATHLETE NAME Last: \_\_\_\_\_ First: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
month day year

## **CERTIFICATION BY PHYSICIANS**

We have examined the athlete named in the application, who has Down Syndrome and who has been diagnosed as having Atlanto-axial Instability. We certify, based on our examinations of the athlete and our review of the health information contained in this application, that despite the diagnosis of Atlanto-axial Instability, this athlete is not medically precluded from participation in Special Olympics. We further certify that we have explained to the athlete named in this application, (and to the parent or guardian whose signature appears below, if the athlete is a minor), the medical risks associated with Atlanto-axial Instability and in particular, the risks associated with the athlete's participation in sports or events which, by their nature, may result in hyper-extension, radical flexion or direct pressure on the neck or upper spine. (Signatures of **two** physicians are required.)

### **Physician #1**

Restrictions (if any): \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Date \_\_\_\_\_

Signature of Physician: \_\_\_\_\_

### **Physician #2**

Restrictions (if any): \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Date \_\_\_\_\_

Signature of Physician: \_\_\_\_\_

## **CERTIFICATION OF ADULT ATHLETE**

**OR**

## **CERTIFICATION OF PARENT/GUARDIAN**

1. I have been informed by the physicians named above that I have Atlanto-axial Instability.
2. The risks associated with that condition, including the risks from participating in equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, and football (soccer) have been fully explained to me by the physicians named above, and I fully understand the possible medical consequences if I participate in any of these sports or events.
3. Although I recognize and understand the risks and possible medical consequences, I certify that I am taking these risks knowingly and voluntarily, of my own free will, because of my desire to participate in Special Olympics, including any or all of the sports/events listed above, based on the certifications of the two physicians named above that I am not medically precluded from participating in Special Olympics.

\_\_\_\_\_  
Signature of Adult Athlete

\_\_\_\_\_  
Date

I hereby certify that I have reviewed this release with the athlete whose signature appears above. I am satisfied, based on that review, that the athlete understands this release and has agreed to its terms.

Name (print): \_\_\_\_\_

Relationship to athlete: \_\_\_\_\_

1. I have been informed by the physicians named above that my son/daughter has Atlanto-axial Instability.
2. The risks associated with that condition, including the risks from participating in equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, and football (soccer) have been fully explained to me by the physicians named above, and I fully understand the possible medical consequences if my son/daughter participate in any of these sports or events.
3. Although I recognize and understand the risks and possible medical consequences, I hereby give my permission for my son/daughter to participate in Special Olympics, including any or all of the sports/events listed above, based on the certifications of the two physicians named above that my son/daughter is not medically precluded from participating in Special Olympics.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

# SPECIAL PROVISIONS REGARDING MEDICAL TREATMENT (Religious Objections Form)



COUNTY: \_\_\_\_\_

SCHOOL/AGENCY: \_\_\_\_\_

ATHLETE NAME Last: \_\_\_\_\_ First: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_  
month / day / year

Special Olympics respects the religious beliefs of all of its athletes. Our standard application form normally requires each athlete (or his/her parent or guardian, if the athlete is a minor), to give Special Olympics permission to arrange for emergency medical treatment (including hospitalization) for any athlete if a medical emergency arises during his/her participation in Special Olympics, under circumstances in which neither the athlete nor his/her parent or guardian is available to consent to that emergency treatment. If you have religious objects to approving that provision, please **cross it out and initial it** on the application form, and submit the application along with this page, after reading and signing it below.

On the attached Official Special Olympics Release Form, I have crossed out, initialed and rejected the provision that authorizes Special Olympics to make arrangements for emergency medical treatment for myself (my son/daughter) if I (my son/daughter) is injured and I (my parents/guardian) are unable to consent to that treatment. I am withholding this permission on religious grounds. However, on behalf of myself and/or my parents/guardian, I do agree to and confirm the following:

**TO BE COMPLETED BY  
ADULT ATHLETE**

**OR**

**TO BE COMPLETED BY  
PARENT/GUARDIAN OF MINOR ATHLETE**

1. I agree to carry with me, at all times during my participation in any Special Olympics training or competition event, a printed card or paper that describes my religious objection, so that in case I get sick or hurt and cannot speak for myself, Special Olympics will be able to read this card and learn of my religious objections to medical treatment.
2. I also agree to make arrangements for an adult friend or member of my family to be present with me on site at all times during my participation in Special Olympics activities, so that this person can take personal responsibility for me if a medical emergency arises and I am unable to speak for myself. I understand that if this friend or family member is not present, I will **not** be permitted to participate in that event, and that no exceptions will be made.
3. I also agree to release Special Olympics and their employees and volunteers from any and all claims, demands or liabilities of any kind that may arise out of Special Olympics' failure to take measures to provide me with emergency medical treatment during Special Olympics events and activities. I am agreeing to this release because I have refused, knowingly and voluntarily to give Special Olympics permission to take such emergency measures, and I am expressly directing Special Olympics not to do so, on religious grounds.

1. I agree to be present with the athlete at all times at the site of any Special Olympics training or competition events in which the athlete will participate, so that I can be readily available to take personal responsibility for the athlete if a medical emergency arises. I understand that if I am not present, the athlete will **not** be permitted to participate in that event, and that no exceptions will be made.
2. I also agree on behalf of myself and the athlete, to release Special Olympics and their employees and volunteers from any and all claims, demands or liabilities of any kind that may arise out of Special Olympics' failure to take measures to provide the athlete with emergency medical treatment during Special Olympics' events and activities. I am agreeing to this release because I have refused, knowingly and voluntarily, to give Special Olympics permission to take such emergency measures, and I am expressly directing Special Olympics not to do so, on religious grounds.

I have read this release, I fully understand what it says and I agree to it.

\_\_\_\_\_  
Signature of Adult Athlete Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

Signature of Family Member/Friend: \_\_\_\_\_

**I have verified with the athlete and/or parent/guardian that they understand this form and do not want medical treatment due to religious objections.**

\_\_\_\_\_  
County Coordinator Signature Date



## *SPECIAL OLYMPICS FLORIDA*

# *ATHLETE CODE OF CONDUCT*

In May 2000, the first Global Athlete Congress was held in The Netherlands. Special Olympics athletes from all over the world met to discuss important issues. These athletes asked for a “Code of Conduct,” or written set of rules for all athletes to follow. All Special Olympics competitors are ambassadors for the Special Olympics movement all around the world. This Code of Conduct holds all Special Olympics athletes to the highest standards of competition in keeping with the Olympic spirit.

Special Olympics show the world the highest ideals of sport just like the Olympic Games. The Special Olympics oath is:

*“Let me win, but if I cannot win, let me be brave in the attempt.”*

Every Special Olympics athlete repeats these words before each competition. The oath is a pledge, or promise, to try to achieve the highest level of competition and good sportsmanship.

As a Special Olympics athlete, I pledge that:

### **RESPECT FOR OTHERS**

- I will respect the rights, dignity and worth of other athletes, coaches, volunteers, friends and spectators in Special Olympics.
- I will treat everyone equally regardless of sex, ethnic origin, religion or ability.
- I will display control, respect, dignity and professionalism to all involved including athletes, coaches, opponents, officials, administrators, parents, spectators and media.

### **SPORTSMANSHIP**

- I will practice good sportsmanship.
- I will not use bad language. I will not swear or insult other persons. I will not fight with other athletes, coaches, volunteers, staff or spectators.
- I will train regularly and commit to knowing and playing by the rules of my sport.
- I will listen to my coaches and the officials and ask questions when I do not understand.
- I will always try my best during training, divisioning and competitions. I will not “hold back” in preliminaries just to get into an easier final heat.



**SPECIAL OLYMPICS FLORIDA  
ATHLETE CODE OF CONDUCT (cont)**

**RESPONSIBILITIES FOR MY ACTIONS**

- I will dress and act, at all times, in a professional manner that will be a credit to Special Olympics. Profanity, taunting and other forms of poor sportsmanship are subject to immediate ejection.
- I will not engage in any type of inappropriate behavior, sexual activity, and/or verbal or physical abuse with either Special Olympics athletes, staff, officials or other volunteers.
- I understand that I am responsible for my own actions, health and safety, to the extent that I am able.
- I will respect the property of hotels, dormitories, athletic facilities and dining facilities.
- I will not take part in the consumption of alcoholic beverages and/or controlled substances during any Special Olympics training or competition.
- I will not take part in smoking or chewing tobacco at any training or competition site except in designated smoking areas.
- I will obey all laws and Special Olympics rules.

**By signing below, I am saying that:**

- I have read (or have had read to me) this Athlete Code of Conduct.
- I agree to obey this Athlete Code of Conduct.
- I understand the words and meaning of this Athlete Code of Conduct.
- I understand that this Athlete Code of Conduct is a general guide for my conduct and does not describe all types of good and bad behavior.
- I understand that if I do not obey this Code of Conduct my Program or a Games Organizing Committee may not allow me to participate.

\_\_\_\_\_   
Print Name of Athlete

\_\_\_\_\_   
County Program

\_\_\_\_\_   
Signature of Athlete

\_\_\_\_\_   
Date

Witness: I hereby certify that I have reviewed this Code of Conduct with the athlete whose signature appears above. I am satisfied, based on that review, that the athlete understands this document and has agreed to its terms.

Witness signature \_\_\_\_\_

Relationship to athlete \_\_\_\_\_

**OR**

I have explained this Code of Conduct to my child/athlete and they understand to the best of their ability. I agree that my child/athlete will be held accountable for their behavior as specified in this Code of Conduct.

\_\_\_\_\_   
Parent/Guardian signature

\_\_\_\_\_   
Date